STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185378	A. BUILDING _____ B. WING _____	C 03/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASONIC HOME OF SHELBYVILLE	711 FRANKFORT ROAD SHELBYVILLE, KY 40066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Complaint Survey was initiated on 03/03/15 and concluded on 03/04/15 to investigate KY22912. The Division of Health Care unsubstantiated the allegation with related deficiencies cited.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, it was determined the facility failed to follow it's Abuse Policy to report an allegation of abuse for one (1) of four (4) sampled residents, (Resident #1). The findings include: Review of the facility's Abuse Policy, revised July 2014, revealed on page four (4) of six (6) under item number seven (7) revealed if there was an allegation of abuse, neglect, or exploitation, the Administrator would notify the Department for Community Based Services (DCBS), the Office of the Inspector General (OIG), and if a suspected crime had been committed, the local police. Notifications would be made within two (2) hours of the facility notification. Review of the facility's investigation conducted on	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185378	A. BUILDING _____ B. WING _____	C 03/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASONIC HOME OF SHELBYVILLE	711 FRANKFORT ROAD SHELBYVILLE, KY 40066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 1 02/25/15 after notification of the alleged physical abuse of Resident #1, revealed no evidence that DCBS or the OIG had been notified of the allegation. Interview with Assistant Director of Nursing, on 03/03/15 at 2:05 PM, revealed when she was notified of the alleged incident of physical abuse against Resident #1 by a Certified Nursing Assistant (CNA), a video was reviewed, staff and two (2) students and their instructor were interviewed, the incident was reported to the Administrator and no futher action had been taken by the facility to notify DCBS or OIG. In addition, she stated the Abuse Policy did state the DCBS and OIG were to have been notified. Interview with the Administrator, on 03/03/15 at 3:40 PM, revealed after viewing the video, he and staff investigating the alleged physical abuse allegation came to the decision the incident was unsubstantiated and DCBS, not OIG, were notified. In addition, he stated the Abuse Policy directed that DCBS and OIG were to be notified.	F 226		
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185378	A. BUILDING _____ B. WING _____	C 03/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASONIC HOME OF SHELBYVILLE	711 FRANKFORT ROAD SHELBYVILLE, KY 40066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 2	F 490		

determined the Administrator failed to follow the Abuse Policy which stated to notify the appropriate agencies of an allegation of suspected Abuse when an allegation of physical abuse towards Resident #1 was reported to the facility.

The findings include:

Review of the facility's Abuse Policy, revised July 2014, revealed the Department for Community Based Services (DCBS), the Office of the Inspector General (OIG), and if applicable the local Police Department were to notified.

Review of the facility's investigation of an alleged physical abuse against Resident #1 on 02/25/15, revealed no evidence was available that DCBS or OIG had been notified of the allegation.

Interview with the Assistant Director of Nursing, on 03/03/15 at 2:05 PM, revealed she was the staff member to whom the allegation of physical abuse had been reported to. This was done by a local school's Clinical Instuctor on 02/25/15. She had only reported the allegation to the Administrator and the Social Services Director. She stated, she had not notified DCBS or OIG.

Interview with the Administrator, on 03/03/15 at 3:40 PM, revealed the alleged physical abuse allegation had been reported to him on 02/25/15. He stated the facility investigated the allegation; however, could not substantiate the allegation and therefore did not report the allegation to DCBS or OIG. In addition, he stated the facility policy stated to report any alleged allegation of abuse to DCBS, OIG, and if applicable the Local Police.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185378	A. BUILDING _____ B. WING _____	C 03/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASONIC HOME OF SHELBYVILLE	**711 FRANKFORT ROAD SHELBYVILLE, KY 40066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE